Supplemental Security Income Request for Information

Social Security Office:	Date:	Contact Person:	Phone:

PART I. TO BE COMPLETED BY THE SOCIAL SECURITY ADMINISTRATION

Department of Veterans Affairs Regional Office •	Veteran's Name (Print first, middle, last)
	VA Claim Number
	Service Serial Number
	Veteran's Date of Birth
	Veteran's Social Security Number
Name of Claimant	Claimant's Social Security Number

The Social Security Administration needs VA benefit information for the person(s) named below. Please show the months in which VA benefits were actually paid, **not** the period for which they were due. If more than one type of VA payment is made to the named person(s), please enter all requested information for each type of payment separately. Follow the instructions in M21-1, Part III, 9.03 to complete this form. Use additional sheets if needed. **REMINDER:** Do not include amounts that are not counted for SSI purposes (e.g., Aid and Attendance and Housebound Allowances).

NAME	RELATIONSHIP TO VETERAN	MONTHS VA PAYMENTS WERE ISSUED IN	
		FROM MO/YR	THRU MO/YR

REMARKS

PART II. TO BE COMPLETED BY THE DEPARTMENT OF VETERANS AFFAIRS

The person(s) named in PART I of this form received VA payments as follows:

A. TYPE OF PAYMENT
(Check One)

☐ Educational Benefits ☐ Pension ☐ Compensation

(Check One)

☐ BASED ON NEED
☐ NOT BASED ON NEED

B. FREQUENCY OF PAYMENT

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Other

In C. through F., please show when VA benefits were actually paid, not the period for which they were due.

PART II (Cont'd)

C. REGULAR MONTHLY VA PAYMENT AMOUNT ATTRIBUTABLE TO VETERAN/WIDOW(ER) IF REQUESTED IN PART I (NOT INCLUDING AMOUNTS FOR DEPENDENTS).

AMOUNT	MONTH CHECK ISSUED IN	
	FROM MO/YR	THRU MO/YR

D. REGULAR MONTHLY VA PAYMENT AMOUNT ATTRIBUTABLE TO DEPENDENT(S) IF REQUESTED IN PART I.

DEPENDENT'S NAME	AMOUNT	MONTH CHECK ISSUED IN	
		FROM MO/YR	THRU MO/YR

E. RETROACTIVE VA PAYMENT AMOUNTS ATTRIBUTABLE TO PERSONS LISTED IN PART I.

NAME	AMOUNT	MONTH CHECK ISSUED IN

F. TOTAL PAYMENT AMOUNT(S) DUE TO UNUSUAL MEDICAL EXPENSES FOR VETERAN/WIDOW(ER) AND ALL DEPENDENTS SINCE _____ .
(This information is needed ONLY if SSA entered a date on the line above. Amounts shown here can include amounts shown in C., D., and E. above. Do not apply an augmentation formula to the amounts shown below).

AMOUNT	MONTH CHECK ISSUED IN	
	FROM MO/YR	THRU MO/YR

G. AMOUNTS WITHHELD FROM AMOUNTS IN C. & D. TO RECOVER VA OVERPAYMENT (OP).

NAME	AMOUNT OF OP	PERIOD OF OP		MONTHLY AMOUNT WITHHELD	MONTHS BENEFIT REDUCED	
		MO/YR	THRU MO/YR		MO/YR	THRU MO/YR

Signature of VA Official Completing Form | Date

Title | Phone (Optional)